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BEFORE THE
PHYSICAL THERAPY BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: PHILIPPE POUILLOUX 9400 Brighton Way #102 Beverly Hills, California 90210 Physical Therapist License No. PT 19442 Respondent.	Case No. 1D 2002 63118 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Steven K. Hartzell (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Physical Therapy Board of California, Department of Consumer Affairs.

2. On or about October 28, 1993, the Physical Therapy Board of California issued Physical Therapist License Number PT 19442 to Philippe Pouilloux (Respondent). The Physical Therapist License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2007, unless renewed.

JURISDICTION

3. This Accusation is brought before the Physical Therapy Board of California (Board), Department of Consumer Affairs, under the authority of the following laws.

All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2609 of the Code states:

The board shall issue, suspend, and revoke licenses and approvals to practice physical therapy as provided in this chapter.

5. Section 2660 of the Code states:

The board may, after the conduct of appropriate proceedings under the Administrative Procedure Act, suspend for not more than 12 months, or revoke, or impose probationary conditions upon any license, certificate, or approval issued under this chapter for unprofessional conduct that includes, but is not limited to, one or any combination of the following causes:

(a) Advertising in violation of Section 17500.

(b) Fraud in the procurement of any license under this chapter.

(c) Procuring or aiding or offering to procure or aid in criminal abortion.

(d) Conviction of a crime which substantially relates to the qualifications, functions, or duties of a physical therapist or physical therapy assistant. The record of conviction or a certified copy thereof shall be conclusive evidence of that conviction.

(e) Impersonating or acting as a proxy for an applicant in any examination given under this chapter.

(f) Habitual intemperance.

(g) Addiction to the excessive use of any habit-forming drug.

(h) Gross negligence in his or her practice as a physical therapist or physical therapy assistant.

(i) Conviction of a violation of any of the provisions of this chapter or of the State Medical Practice Act, or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or of the State Medical Practice Act.

(j) The aiding or abetting of any person to violate this chapter or any

regulations duly adopted under this chapter.

(k) The aiding or abetting of any person to engage in the unlawful practice of physical therapy.

(l) The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, or duties of a physical therapist or physical therapy assistant.

6. Section 2620.7 of the Code states:

(a) A physical therapist shall document his or her evaluation, goals, treatment plan, and summary of treatment in the patient record.

(b) A physical therapist shall document the care actually provided to a patient in the patient record.

(c) A physical therapist shall sign the patient record legibly.

(d) Patient records shall be maintained for a period of no less than seven years following the discharge of the patient, except that the records of unemancipated minors shall be maintained at least one year after the minor has reached the age of 18 years, and not in any case less than seven years.

7. Section 2630 of the Code states:

It is unlawful for any person or persons to practice, or offer to practice, physical therapy in this state for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing the person holds a valid, unexpired, and unrevoked license issued under this chapter.

Nothing in this section shall restrict the activities authorized by their licenses on the part of any persons licensed under this code or any initiative act, or the activities authorized to be performed pursuant to Article 4.5 (commencing with Section 2655) or Chapter 7.7 (commencing with Section 3500).

A physical therapist licensed pursuant to this chapter may utilized the services of one aide engaged in patient-related tasks to assist the physical therapist in his or her practice of physical therapy. "Patient-related task" means a physical therapy service

rendered directly to the patient by an aide, excluding non-patient-related tasks. "Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions. The aide shall at all times be under the orders, direction, and immediate supervision of the physical therapist. Nothing in this section shall authorize an aide to independently perform physical therapy or any physical therapy procedure. The board shall adopt regulations that set forth the standards and requirements for the orders, direction, and immediate supervision of an aide by a physical therapist. The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as, and in proximity to, the location where the aide is performing patient-related tasks, and shall be readily available at all times to provide advice or instruction to the aide. When patient-related tasks are provided to a patient by an aide, the supervising physical therapist shall, at some point during the treatment day, provide direct service to the patient as treatment for the patient's condition, or to further evaluate and monitor the patient's progress, and shall correspondingly document the patient's record.

The administration of massage, external baths, or normal exercise not a part of a physical therapy treatment shall not be prohibited by this section.

8. Section 2655 of the Code states:

As used in this article:

(a) "Physical therapist" means a physical therapist licensed by the board.

(b) "Physical therapist assistant" means a person who meets the qualifications stated in Section 2655.3 and who is approved by the board to assist in the provision of physical therapy under the supervision of a physical therapist who shall be responsible for the extent, kind, and quality of the services provided by the physical therapist assistant.

(c) "Physical therapist assistant" and "physical therapy assistant" shall be deemed identical and interchangeable.

9. Section 2655.7 of the Code states:

Notwithstanding Section 2630, a physical therapist assistant may assist in the provision of physical therapy service provided the assistance is rendered under the supervision of a physical therapist licensed by the board.

10. Section 725 of the Code states:

Repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, or optometrist. However, pursuant to Section 2241.5, no physician and surgeon in compliance with the California Intractable Pain Treatment Act shall be subject to disciplinary action for lawfully prescribing or administering controlled substances in the course of treatment of a person for intractable pain.

11. Section 810 of the Code states:

(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim.

(b) It shall constitute cause for revocation or suspension of a license or certificate for a health care professional to engage in any conduct prohibited under Section 1871.4 of the Insurance Code or Section 550 of the Penal Code.

12. California Code of Regulations, Title 16, section 1398.44, states:

A licensed physical therapist shall at all times be responsible for all physical therapy services provided by the physical therapist assistant. The supervising physical therapist has continuing responsibility to follow the progress of each patient, provide direct care to the patient and to assure that the physical therapist assistant does not function autonomously. Adequate supervision shall include all of the following:

(a) The supervising physical therapist shall be readily available in person or by telecommunication to the physical therapist assistant at all times while the physical therapist assistant is treating patients. The supervising physical therapist shall provide periodic on site supervision and observation of the assigned patient care rendered by the physical therapist assistant.

(b) The supervising physical therapist shall initially evaluate each patient and document in the patient record, along with his or her signature, the evaluation and when the patient is to be reevaluated.

(c) The supervising physical therapist shall formulate and document in each patient's record, along with his or her signature, the treatment program goals and plan based upon the evaluation and any other information available to the supervising physical therapist. This information shall be communicated verbally, or in writing by the supervising physical therapist to the physical therapist assistant prior to initiation of treatment by the physical therapist assistant. The supervising physical therapist shall determine which elements of the treatment plan may be assigned to the physical therapist assistant. Assignment of these responsibilities must be commensurate with the qualifications, including experience, education and training, of the physical therapist assistant.

(d) The supervising physical therapist shall reevaluate the patient as previously determined, or more often if necessary, and modify the treatment, goals and plan as needed. The reevaluation shall include treatment to the patient by the supervising physical therapist. The reevaluation shall be documented and signed by the supervising physical therapist in the patient's record and shall reflect the patient's progress toward the

treatment goals and when the next reevaluation shall be performed.

(e) The physical therapist assistant shall document each treatment in the patient record, along with his or her signature. The physical therapist assistant shall document in the patient record and notify the supervising physical therapist of any change in the patient's condition not consistent with planned progress or treatment goals. The change in condition necessitates a reevaluation by a supervising physical therapist before further treatment by the physical therapist assistant.

(f) Within seven (7) days of the care being provided by the physical therapist assistant, the supervising physical therapist shall review, cosign and date all documentation by the physical therapist assistant or conduct a weekly case conference and document it in the patient record. Cosigning by the supervising physical therapist indicates that the supervising physical therapist has read the documentation, and unless the supervising physical therapist indicates otherwise, he or she is in agreement with the contents of the documentation.

(g) There shall be a regularly scheduled and documented case conference between the supervising physical therapist and physical therapist assistant regarding the patient. The frequency of the conferences is to be determined by the supervising physical therapist based on the needs of the patient, the supervisory needs of the physical therapist assistant and shall be at least every thirty calendar days.

(h) The supervising physical therapist shall establish a discharge plan. At the time of discharge, or within 7 (seven) days thereafter, a supervising physical therapist shall document in the patient's record, along with his or her signature, the patient's response to treatment in the form of a reevaluation or discharge summary."

13. California Code of Regulations, Title 16, section 1399, states:

A physical therapy aide is an unlicensed person who assists a physical therapist and may be utilized by a physical therapist in his or her practice by performing nonpatient related tasks, or by performing patient related tasks.

(a) As used in these regulations:

(1) A “patient related task” means a physical therapy service rendered directly to the patient by an aide, excluding nonpatient related tasks as defined below.

(2) A “nonpatient related task” means a task related to observation of the patient, transport of patients, physical support only during gait or transfer training, housekeeping duties, clerical duties and similar functions.

(b) “Under the orders, direction and immediate supervision” means:

(1) Prior to the initiation of care, the physical therapist shall evaluate every patient prior to the performance of any patient related tasks by the aide. The evaluation shall be documented in the patient's record.

(2) The physical therapist shall formulate and record in the patient's record a treatment program based upon the evaluation and any other information available to the physical therapist, and shall determine those patient related tasks which may be assigned to an aide. The patient's record shall reflect those patient related tasks that were rendered by the aide, including the signature of the aide who performed those tasks.

(3) The physical therapist shall assign only those patient related tasks that can be safely and effectively performed by the aide. The supervising physical therapist shall be responsible at all times for the conduct of the aide while he or she is on duty.

(4) The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as and in immediate proximity to the location where the aide is performing patient related tasks, and shall be readily available at all times to provide advice or instruction to the aide. When patient related tasks are provided a patient by an aide the supervising physical therapist shall at some point during the treatment day provide direct service to the patient as treatment for the patient's condition or to further evaluate and monitor the patient's progress, and so document in the patient's record.

(5) The physical therapist shall perform periodic re-evaluation of the patient as necessary and make adjustments in the patient's treatment program. The re-evaluation shall be documented in the patient's record.

(6) The supervising physical therapist shall countersign with their first initial and last name, and date all entries in the patient's record, on the same day as patient related tasks were provided by the aide.

14. Section 2661.5 of the Code states:

(a) In any order issued in resolution of a disciplinary proceeding before the board, the board may request the administrative law judge to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

(b) The costs to be assessed shall be fixed by the administrative law judge and shall not in any event be increased by the board. When the board does not adopt a proposed decision and remands the case to an administrative law judge, the administrative law judge shall not increase the amount of the assessed costs specified in the proposed decision.

(c) When the payment directed in an order for payment of costs is not made by the licensee, the board may enforce the order of payment by bringing an action in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee directed to pay costs.

(d) In any judicial action for the recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(e) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license or approval of any person who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license or approval of any person who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one year

period for those unpaid costs.

(f) All costs recovered under this section shall be deposited in the Physical Therapy Fund as a reimbursement in either the fiscal year in which the costs are actually recovered or the previous fiscal year, as the board may direct.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

15. Respondent is subject to disciplinary action under section 2660, subdivision (h), in that Respondent engaged in gross negligence in his practice as a physical therapist. The circumstances are as follows:

Factual Allegations re Patient M.M.

A. On or about August 29, 2001, respondent first saw and evaluated patient M.M. who complained of pain in her neck, shoulders, and lower back due to an injury from an automobile accident. The chart does not contain a substantiated diagnosis from the patient's referring physician. There was no specific treatment plan in the initial evaluation to address the patient's specific impairments. The patient was treated about 44 times until December 28, 2001. Respondent billed patient M.M.'s insurance company about 34 times for joint mobilization, a technique applied by a physical therapist because a patient has limited accessory mobility of specific spinal segments. However, patient M.M. stated her treatments consisted of Pilates exercises with a trainer, and that respondent did not provide any joint mobilization techniques.

B. There was no indication in the patient's initial evaluation or in her progress notes of specific spinal segment hypomobility, including what spinal segments were involved, which techniques of joint mobilization were used, in what manner, and the results. There was no specific information about a given treatment documented, including what part of the body was treated, how the treatments were provided, the frequency and duration, and the patient's response to the treatments. There was no documentation that respondent scheduled or periodically re-assessed the patient and changed or updated the physical therapy plan or scheduled such a reassessment. All of

the treatments were essentially the same. There was no evidence of progress in the patient's chart.

C. Patient M.M. stated that her visits consisted of working out with a trainer doing Pilates exercises, and that she also received treatments from a massage therapist. There was no documentation in the progress notes regarding a Pilates trainer or a massage therapist. There was no documentation of the type of exercises she was doing and how the exercises related to treating her weakness and her postural deficits. Endurance was not re-tested and/or addressed during treatments. There was no documentation of patient education for posture and functional mobility. There was no indication that respondent adequately supervised the Pilates instructors and massage therapists who were seeing the patient. The patient's progress notes were signed by the physical therapist assistant S.R., but were not co-signed by respondent on September 19, 21, 30, October 1, 3, 15, 24, and on November 7, 2001. Respondent did not properly supervise the physical therapy assistant and provide care planning for the patient.

D. The patient's insurance company was billed for physical therapy including, therapeutic exercises, neuromuscular therapy, manual therapy, joint mobilization and other activities, from September 5, 2001 through December 28, 2001.

Allegations of Gross Negligence re Patient M.M.

E. Between on or about August 29, 2001, and December 28, 2001, respondent was grossly negligent in providing physical therapy services to patient M.M. based on the following:

1. Respondent failed to create a specific treatment plan for the patient.

2. Respondent charted joint mobilization therapy for the patient when it was neither given nor indicated.

3. Respondent failed to chart specific information about treatments documented, such as the part of the body treated, how the treatments were provided, the treatment duration and frequency, and the patient's response

to the treatment.

4. Respondent failed to document any periodic reassessment of the patient and to change or update the treatment plan accordingly.

5. With respect to Pilates exercises, respondent failed to document the type of exercises ordered nor their relationship to the patient's presentation; respondent failed to assess the patient's endurance during Pilates treatments; and respondent failed to properly supervise aides providing Pilates treatments and/or to ensure that the aides properly documented the patient chart.

6. Respondent failed to co-sign the patient chart for treatments provided by a physical therapy assistant on September 19, 21, 30, October 1, 3, 15, 24, and on November 7, 2001.

7. Respondent failed to properly supervise the physical therapy assistant providing physical therapy services to the patient.

8. Respondent knowingly prepared, made, or subscribed the patient chart with intent to present or use it, or to allow it to be presented or used in support of a false or fraudulent claim, to wit, that physical therapy services had been provided by a licensed physical therapist or by properly supervised physical therapy assistants or aides.

9. Respondent knowingly prepared, made, or subscribed the patient chart with intent to present or use it, or to allow it to be presented or used in support of a false or fraudulent claim, to wit, that joint mobilization therapy had been provided to the patient.

Factual Allegations re Patient P.K.

F. On or about May 7, 2001, respondent first saw and evaluated patient P.K. who complained of pain in her neck, shoulders, back, feet and hands due to fibromyalgia, lupus and arthralgia. The patient received about 168 treatments through May 24, 2003. She signed a Pilates protocol on July 31, 2002. Most of the progress notes were signed

by respondent or another physical therapist, or signed by a physical therapist assistant and co-signed by respondent. The progress notes were signed by a physical therapist assistant, but were not co-signed by respondent on May 10, 14, 17, 21, 24, 29, June 6, 11, 14, 18, 21, 27, 28, October 1, 8, 10, 15, 22, 24, 29, 31, November 5, 7, 12, 14, 20, 21, 26, 28, 30, and on December 3 and 6, 2001. On August 21 and December 12, 2002, the notes were not signed by anyone. Next to the May 13, 2002, treatment entry there was a Post-it note written by one of the Pilates instructors indicating, "[P.K.] has a rotator cuff injury going. Watch the angles she's working in. She needs to keep her pectoralii open and be in external rotation @ lifted sternum." None of the progress notes mentioned this treatment precaution; such treatment parameters should be set by a licensed physical therapist, not an aide. The patient was discharged on July 7, 2003. Respondent did not prepare a discharge summary or reevaluation which documented the patient's response to treatment.

G. On October 15, 2003, P.K.'s physician wrote a prescription for Pilates treatment. P.K. had another initial evaluation on October 20, 2003. Her progress notes, which were signed by respondent, indicated she was treated about 32 times from October 27, 2003, to January 28, 2004. All of the progress notes were essentially the same. The chart does not reflect objective findings, reassessments, change in the treatment plan, and specific information about a given treatment. The patient's last visit was on January 28, 2004. Respondent did not prepare a discharge summary or reevaluation which documented the patient's response to treatment. There was no indication in the chart that respondent set the guidelines for Pilates and determined the treatment exercises for the patient. There was no documentation regarding who gave the treatments to the patient. There was no indication that respondent adequately supervised the Pilates instructors and massage therapists who were seeing the patient.

H. Respondent billed Blue Cross, the patient's insurance company, for physical therapy services from May 2001, through February 2004.

Allegations of Gross Negligence re Patient P.K.

I. Between on or about May 7, 2001, and January 28, 2004, respondent was grossly negligent in providing physical therapy services to patient P.K. based on the following:

1. Respondent failed to co-sign progress notes created by a physical therapist assistant under his supervision on or about May 10, 14, 17, 21, 24, 29, June 6, 11, 14, 18, 21, 27, 28, October 1, 8, 10, 15, 22, 24, 29, 31, November 5, 7, 12, 14, 20, 21, 26, 28, 30, and on December 3 and 6, 2001.

2. On or about May 13, 2002, respondent failed to properly supervise physical therapy services provided by aides by permitting an aide to set treatment parameters for the patient.

3. Between October 27, 2003, and January 28, 2004, respondent failed to ensure that the patient chart reflected objective findings, reassessments, changes in the treatment plan and specific information about given treatments.

4. On or about January 28, 2004, respondent failed to prepare a discharge summary or evaluation which indicated the patient's response to the therapy.

5. With respect to the provision of Pilates therapy between on or about October 27, 2003, and January 28, 2004, respondent failed to set and/or document the guidelines for Pilates exercises by determining the treatment exercises for the patient; failed to ensure proper documentation regarding who gave the Pilates treatments to the patient and to co-sign the chart; and failed to adequately supervised the aides who were providing the Pilates treatment to the patient.

6. Respondent knowingly prepared, made, or subscribed the patient chart with intent to present or use it, or to allow it to be presented or used, in support of a false or fraudulent claim, to wit, that physical therapy services had been provided by a licensed physical therapist or by properly

supervised physical therapy assistants or aides.

Factual Allegations re Patient L.B.

J. On or about September 23, 2002, respondent first saw and evaluated patient L.B. who complained of upper back and neck pain due to a sprain. The patient was seen about 64 times until May 14, 2003. The physical therapy progress notes were signed by respondent or another physical therapist, except for the May 14, 2003 note which is unsigned. There was one progress report dated October 18, 2002. All of the progress notes were essentially the same. The chart does not reflect objective findings, reassessments, changes in the treatment plan, specific information about a given treatment and goals. The patient signed a Pilates protocol on October 21, 2002. There was no mention of Pilates in the notes. There was no indication in the chart that respondent set the guidelines for Pilates and determined the treatment exercises for the patient. There was no documentation regarding who gave the treatments to the patient. There was no indication that respondent adequately supervised the Pilates instructors who were seeing the patient. The progress note for the patient's last visit on May 14, 2003 stated, "Pt's shoulders are out of pain." Respondent did not prepare a discharge summary or reevaluation which documented the patient's response to treatment.

K. The partial billing records which respondent provided indicated that Kemper Insurance Company was billed for physical therapy on January 27, February 4, 18, July 23, 28, 30, and on August 1, 4, 7, 11, 14, 18, 21 and 28, 2003.

Allegations of Gross Negligence re Patient L.B.

L. Between on or about September 23, 2002, and May 14, 2003, respondent was grossly negligent in providing physical therapy services to patient L.B. based on the following:

1. Respondent failed to ensure that the patient chart reflected objective findings, reassessments, changes in the treatment plan, and specific information about a given treatment and goals.

2. With respect to the provision of Pilates therapy, respondent failed

to set and/or document the guidelines for Pilates exercises by determining the treatment exercises for the patient; failed to ensure proper documentation regarding who gave the Pilates treatments to the patient and to co-sign the chart; and failed to adequately supervised the aides who were providing the Pilates treatment to the patient.

3. Respondent knowingly prepared, made, or subscribed the patient chart with intent to present or use it, or to allow it to be presented or used, in support of a false or fraudulent claim, to wit, that physical therapy services had been provided by a licensed physical therapist or by properly supervised physical therapy assistants or aides.

Factual Allegations re Patient M.K.

M. On or about December 9, 2002, respondent first saw and evaluated patient M.K. who complained of pain in her left hip, knee and thigh due to osteoarthritis. M.K. was a Medicare patient who could only be seen by a licensed physical therapist or physical therapy assistant. Patient M.K. signed a Pilates protocol on December 9, 2002. On December 18, 2002, a Pilates routine was created for the patient by the Pilates instructor V.J. The patient was seen about 22 times until April 1, 2003. The progress notes were signed by respondent or other physical therapists except for the January 6, 2002 note which was unsigned. The notes mentioned the patient's subjective complaint of pain, but there was no documentation regarding an evaluation of the pain and no objective description of the pain. The notes do not include an assessment, a treatment plan, a progression of therapy or the patient's response to therapy, other than that the treatments were "tolerated well". The chart does not contain a report to a physician regarding the patient's progress. There was no indication in the chart that respondent set the guidelines for Pilates and determined the treatment exercises for the patient. There was no documentation regarding who gave the Pilates treatments to the patient. There was no indication that respondent adequately supervised the Pilates instructors who were seeing the patient. The patient's last visit was on April 1, 2003. Respondent did not

prepare a discharge summary or reevaluation which documented the patient's response to treatment.

N. Respondent provided insurance benefit summaries from United Healthcare Insurance Company for patient M.K. for January 8, 13, 15, 23, and March 19, 2003. The records did not indicate what services were billed.

Allegations of Gross Negligence re Patient M.K.

O. Between on or about December 18, 2002, and April 1, 2003, respondent was grossly negligent in providing physical therapy services to patient M.K. based on the following:

1. Respondent failed to document any evaluation of the patient's subjective complaints of pain nor to document any objective description of the pain.

2. Respondent failed to provide a report to the referring physician regarding the patient's progress.

3. With respect to the provision of Pilates therapy, respondent failed to set and/or document the guidelines for Pilates exercises by determining the treatment exercises for the patient; failed to ensure proper documentation regarding who gave the Pilates treatments to the patient and to co-sign the chart; and failed to adequately supervised the aides who were providing the Pilates treatment to the patient.

4. Respondent knowingly prepared, made, or subscribed the patient chart with intent to present or use it, or to allow it to be presented or used, in support of a false or fraudulent claim, to wit, that physical therapy services had been provided by a licensed physical therapist or by properly supervised physical therapist assistants.

Factual Allegations re Patient S.R.

P. On or about July 1, 2002, respondent first saw and evaluated patient S.R. who complained of pain in his lower back due to degenerative disease of the spine. S.R.

was a Medicare patient who could only be seen by a licensed physical therapist or physical therapy assistant. The patient signed a Pilates protocol on August 6, 2002. The patient was seen about 27 times from July 1, 2002, through May 27, 2003. All of the notes were signed by respondent except for the note dated April 2, 2003, which was signed by another physical therapist. In the daily treatment notes signed by respondent, there was no documentation of the objective status, no treatment description, and no description of the patient's tolerance of the treatments. The chart does not contain reassessments and progress reports to the patient's physician. Although S.R. was a Pilates patient, there was no mention of Pilates in the progress notes. There was no indication that respondent adequately supervised the Pilates instructors who were seeing the patient. There was no documentation regarding who gave the treatments to the patient. There was no indication in the chart that respondent set the guidelines for Pilates and determined the treatment exercises for the patient. The patient's last visit was on May 27, 2003. Respondent did not prepare a discharge summary or reevaluation which documented the patient's response to treatment.

Q. Respondent provided Blue Cross explanation of benefits forms for July 8, 9, 16, September 10, October 16, 22, and November 6, 12, 27, 2002, January 16, and April 15 and 22, 2003 for physical therapy services.

Allegations of Gross Negligence re Patient S.R.

R. Between on or about July 1, 2002, and May 27, 2003, respondent was grossly negligent in providing physical therapy services to patient S.R. based on the following:

1. Respondent failed to chart in the daily treatment notes for the patient the patient's objective status, a description of treatments provided and a description of the patient's tolerance of the treatments provided.

2. Respondent failed to chart and provide to the patient's referring physician reassessments and progress reports.

3. With respect to the provision of Pilates therapy, respondent failed

to set and/or document the guidelines for Pilates exercises by determining the treatment exercises for the patient; failed to ensure proper documentation regarding who gave the Pilates treatments to the patient and to co-sign the chart; and failed to adequately supervised the aides who were providing the Pilates treatment to the patient.

4. Respondent failed to prepare a discharge summary for the patient.

5. Respondent knowingly prepared, made, or subscribed the patient chart with intent to present or use it, or to allow it to be presented or used, in support of a false or fraudulent claim, to wit, that physical therapy services had been provided by a licensed physical therapist or by properly supervised physical therapist assistants.

Factual Allegations re Patient J.M.

S. On or about October 6, 2001, patient J.M. had his first visit with respondent. Patient J.M. was seen about 157 times from October 6, 2001, through May 13, 2003. The chart does not contain an initial evaluation or evidence of a diagnosis from a physician. The patient signed a Pilates protocol on July 31, 2002. The progress notes were signed by a physical therapist assistant, but not co-signed by respondent on October 6, 16, 18, 20, 23, 25, 27, 30, November 1, 3, 6, 8, 10, 13, 16, 21, 23, 24, 27, 29, December 4, 6, 7, 11, 13, 15, 18, 22, 26, 28, 29, 2001, and on January 2, 5, 8, 10, 12, 15, 17, 19, 26, 29 and 31, 2002. The notes dated February 2, March 30 and July 6, 2002 were unsigned. The other progress notes were signed by respondent or another physical therapist. The chart does not contain objective findings, reassessments, changes in the treatment plan, specific information about a given treatment and goals. The chart does not contain progress reports to the patient's physician. There was no mention of Pilates in the notes. There was no indication in the chart that respondent set the guidelines for Pilates and determined the treatment exercises for the patient. There was no documentation regarding who gave the treatments to the patient. There was no indication that respondent adequately supervised the Pilates instructors who were seeing the patient.

The patient's last visit was on May 13, 2003. Respondent did not prepare a discharge summary or reevaluation which documented the patient's response to treatment.

T. Respondent provided explanation of benefit forms from Blue Shield and Aetna for April 6, 9, 11, 13, 18, 20, 23, 25, 27, 30, May 4, 7, 9, 11, 14, 16, 17, 2002, and March 24, April 7, 12, 14, 24 and May 5, 2003 for physical therapy services.

Allegations of Gross Negligence re Patient J.M.

U. Between on or about October 6, 2001, and May 13, 2003, respondent was grossly negligent in providing physical therapy services to patient J.M. based on the following:

1. Respondent failed to chart an initial evaluation of the patient, or evidence of a diagnosis by a licensed diagnostician.

2. Respondent failed to co-sign chart entries of a physical therapy assistant on or about October 6, 16, 18, 20, 23, 25, 27, 30, November 1, 3, 6, 8, 10, 13, 16, 21, 23, 24, 27, 29, December 4, 6, 7, 11, 13, 15, 18, 22, 26, 28, 29, 2001, and on January 2, 5, 8, 10, 12, 15, 17, 19, 26, 29 and 31, 2002.

3. Respondent failed to co-sign and to ensure that the physical therapy assistant signed the chart on February 2, March 30 and July 6, 2002.

4. Respondent failed to ensure that the patient chart reflected objective findings, reassessments, changes in the treatment plan, and specific information about a given treatment and goals.

5. Respondent failed to chart and provide to the patient's referring physician reassessments and progress reports.

6. With respect to the provision of Pilates therapy, respondent failed to set and/or document the guidelines for Pilates exercises by determining the treatment exercises for the patient; failed to ensure proper documentation regarding who gave the Pilates treatments to the patient

and to co-sign the chart; and failed to adequately supervised the aides who were providing the Pilates treatment to the patient.

7. Respondent failed to prepare a discharge summary for the patient.

8. Respondent knowingly prepared, made, or subscribed the patient chart with intent to present or use it, or to allow it to be presented or used, in support of a false or fraudulent claim, to wit, that physical therapy services had been provided by a licensed physical therapist or by properly supervised physical therapist assistants or aides.

Factual Allegations re Patient I.R.

V. On or about October 9, 2002, respondent first saw and evaluated patient I.R. who complained of pain in his neck to his lower back due to a motor vehicle accident. The patient was seen about 30 times until February 14, 2003. Respondent signed all of the progress notes except for the note dated December 26, 2002, which was signed by another physical therapist. All of the progress notes were essentially the same. The chart does not reflect objective findings, reassessments, change in the treatment plan, and specific information about the treatments and goals. Patient M.J. signed a Pilates protocol on November 22, 2002. There was no mention of Pilates in the notes. There was no indication in the chart that respondent set the guidelines for Pilates and determined the treatment exercises for the patient. There was no documentation regarding who gave the treatments to the patient. There was no indication that respondent adequately supervised the Pilates instructors who were seeing the patient.

Allegations of Gross Negligence re Patient I.R.

W. Between on or about October 9, 2002, and February 14, 2003, respondent was grossly negligent in providing physical therapy services to patient I.R. based on the following:

1. Respondent failed to ensure that the patient chart reflected objective findings, reassessments, changes in the treatment plan, and specific information about a given treatment and goals.

2. With respect to the provision of Pilates therapy, respondent failed to set and/or document the guidelines for Pilates exercises by determining the treatment exercises for the patient; failed to ensure proper documentation regarding who gave the Pilates treatments to the patient and to co-sign the chart; and failed to adequately supervised the aides who were providing the Pilates treatment to the patient.

Factual Allegations re Patient M.S.

X. On or about January 2, 2003, respondent first saw and evaluated patient M.S. who complained of pain in his neck, back and knee hands due to an automobile accident. The patient was seen about ten times until March 16, 2003. The physical therapy progress notes were signed by respondent or another physical therapist. Except for the February 27, 2003 note, the progress notes do not include an assessment, a treatment plan, a progression of therapy or the patient's response to therapy. The chart does not contain a report to a physician regarding the patient's progress. The patient's last visit was on March 16, 2003. The record does not indicate the reason the patient stopped treatments. Respondent did not prepare a discharge summary or reevaluation which documented the patient's response to treatment.

Allegations of Gross Negligence re Patient M.S.

Y. Between on or about January 2, 2003, and March 16, 2003, respondent was grossly negligent in providing physical therapy services to patient M.S. based on the following:

1. Respondent failed to ensure that the patient chart reflected objective findings, a treatment plan, reassessments, changes in the treatment plan based on patient progress, and specific information about a given treatment and goals.

2. Respondent failed to chart and provide to the patient's referring physician reassessments and progress reports.

3. Respondent failed to prepare a discharge summary for the patient.

SECOND CAUSE FOR DISCIPLINE

(Failure to Properly Document Treatment)

16. Respondent is subject to disciplinary action under section 2620.7, in conjunction with California Code of Regulations, Title 16, section 1398.44 and 1399 in that Respondent failed to properly document physical therapy treatments for patients M.M., P.K., L.B., M.K., S.R., M.J., I.R. and M.S. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 15 above are incorporated here as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Presenting False Statements)

17. Respondent is subject to disciplinary action under section 810 of the Code in that Respondent knowingly prepared, made, or subscribed the patient charts with intent to present or use them, or to allow them to be presented or used, in support of false or fraudulent claims, to wit, that physical therapy services had been provided by a licensed physical therapist or by properly supervised physical therapy assistants or aides. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 15 above are incorporated here as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Dishonesty)

18. Respondent is subject to disciplinary action under Code section 2660, subdivision (l), in that respondent committed fraudulent, dishonest or corrupt acts which were substantially related to the qualifications, functions or duties of a physical therapist. The circumstances are as follows:

A. The facts and circumstances alleged in paragraphs 15 and 17 above are incorporated here as if fully set forth.

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FIFTH CAUSE FOR DISCIPLINE

(Aiding and Abetting the Excessive Treatment of Patients and/or Excessive Treatment of Patients)

19. Respondent is subject to disciplinary action under section 2660, subdivision (k), and 725, in that Respondent aided and abetted in the practice of clearly excessive treatment of patients and/or clearly excessively treated patients with physical therapy services. The circumstances are as follows:

A. With respect to patient P.K., the patient received clearly excessive physical therapy treatments on numerous occasions between May 7, 2001 and January 28, 2004.

B. With respect to patient L.B., the patient received clearly excessive physical therapy treatments on numerous occasions between September 23, 2002 and May 14, 2003.

C. With respect to patient S.R., the patient received clearly excessive physical therapy treatments on numerous occasions between July 1, 2002 and May 27, 2003.

D. With respect to patient M.J., the patient received clearly excessive physical therapy treatments on numerous occasions between October 6, 2001 and May 13, 2003.

SIXTH CAUSE FOR DISCIPLINE

(Aiding and Abetting the Unlawful Practice of Physical Therapy)

20. Respondent is subject to disciplinary action under Business and Professions Code sections 2630 and 2660, subdivisions (j) and (k), in conjunction with California Code of Regulations, Title 16, sections 1398.44, and 1399, in that he aided and abetted the unlawful practice of physical therapy in the use of physical therapy aides and physical therapy assistants. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 15 above are incorporated here as if fully set forth.

B. Respondent aided and abetted the unlawful practice of physical therapy by

physical therapy aides and physical therapy assistants by permitting them to provide physical therapy services to the above-mentioned patients without proper supervision, by failing to document the delegation of duties to the aides, by failing to provide direct services to the patients who were treated by the aides and by permitting the physical therapy aides to provide services to Medicare patients who could only be treated by a physical therapist or a physical therapist assistant.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physical Therapy Board of California issue a decision:

1. Revoking or suspending Physical Therapist License Number PT 19442, issued to Philippe Pouilloux;

2. Ordering Philippe Pouilloux to pay the Physical Therapy Board of California the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 2661.5;

3. Taking such other and further action as deemed necessary and proper.

DATED: July 6, 2006

Original Signed By:
STEVEN K. HARTZELL
Executive Officer
Physical Therapy Board of California
Department of Consumer Affairs
State of California

Complainant

LA2005600783

Pouilloux Accusation.wpd